DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

jst

PRINTED: 02/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 01 B. WING _____	02/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE CENTER	710 MICHIGAN ST LOWELL, IN 46356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/03/11 Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Lowell Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility was built as a two story building over a partial basement with a two story addition offset and connected to the original structure by a stairway. The construction was determined to be of Type II (111) construction and was fully sprinklered. The facility was surveyed under the existing code since all construction was completed prior to March 1, 2003. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in first floor east resident rooms. The facility has a capacity of 100 and had a census of 66 at the time of this survey.	K 000	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. RECEIVED FEB 24 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH ENTERED FEB 25 2011	

APPROVED
3/1/11 DA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gregory J. Schiavone	Administrator	2/23/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 02/09/11. The facility was found not in compliance with the aforementioned requirements as evidenced by:	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure openings through smoke barriers in 5 of 16 resident use smoke compartments were protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and all residents on 2 of 2 occupied floors.	K 025	**K 025** 1. All openings through the smoke barriers listed were sealed with appropriate material. 2. All smoke barriers in the building were inspected and sealed if needed. 3. The maintenance director was in-serviced to ensure any openings through a smoke barrier are sealed with appropriate material. 4. The administrator or designee will walk through with the maintenance director to inspect all smoke barriers and ensure all openings are sealed. The facility has added the inspection of all smoke barriers to the quarterly preventative maintenance schedule. 5. Completion date 3/5/11	

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K 025	Continued From page 2 Findings include: Based on observation with the maintenance director on 02/03/11 between 12:20 p.m. and 4:30 p.m., the following had unsealed penetrations of the smoke barriers or penetrations sealed with a foam product without a fire rating: a. Two penetrations in the fire smoke barrier wall near room 101 were sealed with a shiny clear material resembling silicone caulk. The maintenance director said at the time of observation, he did not know what the sealant was and could provide no fire rating information for the material; b. A two inch pipe penetrated the boiler room floor in the penthouse leaving an unsealed annular gap which was not sealed around the sprinkler pipe penetrating the ceiling of the second floor west corridor below; c. The second floor west floor boiler room wall was unsealed around a pipe penetrating the wall leaving a half inch gap into an adjacent HVAC room; d. The cross corridor smoke barriers on the second floors had half inch gaps around unsealed penetrations and the barriers were unsealed at the meeting edges between the ceilings and the corrugated steel of the floor deck above which left 3/4 inch gaps at intervals across the width of the corridors above the suspended ceilings; e. The smoke barrier wall above the suspended ceiling between the main dining room and adjacent corridor was unsealed around a two inch pipe leaving a half inch gap around the penetration; f. The smoke barrier near room 101 had an unsealed two inch hole and a one inch gap around an unsealed pipe penetration; g. Two 3/4 inch holes in the ceiling of the second	K 025		

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K 025	Continued From page 3 floor elevator enclosure were unsealed; h. A half inch gap was unsealed in the smoke barrier between the second floor elevator enclosure and the adjacent resident wing; The maintenance director agreed at the times of observations, the gaps should have been sealed with a fire rated material. 3.1-19(b)	K 025		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 1. Based on record review and interview, the facility failed to ensure documentation for the annual testing of 1 of 1 fire alarm system's components and devices such as smoke detectors, heat sensors and fire alarm pull stations was complete. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors, heat sensors, fire alarm pull stations, and fire alarm control equipment be tested annually. The inspection should include locations and serial numbers, the test/inspection done and whether each device passed or failed. This	K 052	K 052 1. The number of heat detectors listed on the Heat Detector Test Report was updated and all units were tested and functioning. The Duct Detector Test Report was updated to include all nine duct detectors. The detector on the 4th floor was replaced, tested, and functioning. The Fire Alarm Inspection Report was completed to show the "Current Test" and "Test Results." All sensitivity tests were in range. 2. A complete inspection of the facility fire alarm system was tested	

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K 052	Continued From page 4 deficient practice could affect all occupants. Findings include: Based on review of the facility's most recent 01/21/10 fire alarm system Inspectors Test Report for the annual inspection and function test of system components with the maintenance director and administrator on 02/03/11 at 1:05 p.m., a discrepancy existed in the number of heat detectors listed under "units tested" and the Heat Detector Test Report which noted three heat detectors tested. The Duct Detector Test Report listed nine duct detectors, eight duct detectors were listed and no result for a ninth duct detector was listed. One detector located "4th floor in attic by stairs" was noted to have "no power needs replaced." The maintenance director said at the time of observation, he did not know how many duct detectors were in the facility, he thought the faulty detector had been replaced but could provide no documentation it was done. His immediate call to the contractor produced no new information. Of 42 smoke detectors located throughout the facility, results for function testing listed on the Smoke Detector Test Report omitted test results for smoke detectors in the "elevator mechanical room and by elevator (in zones 8, 9 and 12)." The maintenance director said he did not know why their function test results were not included for these areas. The most current smoke detector sensitivity report was dated 09/25/08. The administrator explained at the time of record review, there was no more current record, the fire alarm system inspection and test contractor was in to perform all testing "last week" and had left testing equipment but no record of any testing done was provided. The administrator did not know why the contractors	K 052	for functioning and sensitivity. All units are working properly. 3. The maintenance director was in-serviced to ensure all reports received from the fire system inspection company are reviewed and verified that all units were tested and working properly. 4. The administrator will review all fire system inspection reports to ensure the information is complete and all units were tested and working properly. 5. Completion date 3/5/11	

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K 052	Continued From page 5 had not returned during any of the four business days this week. 3-1.19(b) 2. Based on record review and interview, the facility failed to ensure 100% of the smoke detectors had been sensitivity tested as required. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.	K 052		

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K 052	Continued From page 6 Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector." This deficient practice affects all occupants. Findings include: The most recent Fire Alarm Inspection Report dated 01/21/10 was reviewed with the maintenance director and administrator on 02/03/11 at 1:05 p.m. and the report was incomplete. The record noted each smoke detector, its location and the range within which each detector should test, however, Prior Test and Current Test columns were marked with "N/A" and the Test Result column was left blank. The maintenance director said at the time of review, this was the record provided for sensitivity testing and he had no other sensitivity test for review. 3.1-19(b)	K 052		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure required sprinkler waterflow	K 062		

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K 062	Continued From page 7 alarm devices were tested quarterly for 2 of 4 quarters and complete documentation was provided. NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, at 2-3.3 requires waterflow alarm devices including but not limited to mechanical water motor gongs, vane-type waterflow devices, and pressure switches providing audible or visual signals shall be tested quarterly. NFPA 25, 9-4.4.2.1 requires priming level shall be tested quarterly. NFPA 25, 9-7.1 requires fire department connections shall be inspected quarterly. NFPA 25, 1-8.1 requires records shall indicate the procedure performed (inspection, test, or maintenance), the organization performing the work, the results and the date. Finally, NFPA 25, 1-8 requires records of inspection, test, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include but are not limited to valve inspections, flow, drain, and pump tests; and trip tests of dry pipe, deluge and preaction valves. This deficient practice affects all occupants in the facility. Findings include: Based on review of sprinkler system inspection records with the maintenance director and administrator on 02/03/11 at 1:25 p.m., a quarterly Sprinkler System Inspection Report dated 07/22/10 and a Customer Service Report indicating an annual inspection of the sprinkler system were the only documents of inspection and testing of the sprinkler system during the past year. The Customer Service Report dated 11/11/10 noted the annual sprinkler inspection was done and testing of the antifreeze system,	K 062	K 062 1. The test results of the sprinkler inspection dated 11/11/10 was received. 2. A contract has been put into place with a local vendor to ensure the sprinkler system is tested quarterly. 3. The maintenance director was re-educated to ensure the sprinkler systems are tested quarterly and the facility receives the inspection report. 4. The administrator will review the quarterly sprinkler inspections with the maintenance director to ensure the sprinkler system is tested and the correct information is received. 5. Completion date 3/5/11	

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K 062	Continued From page 8 tamper switches, control valves, and flow switches was done, however test results and other details were not included in the report. The maintenance director called the contractor immediately to request the missing information but none was received at the completion of the visit on 02/03/11 at 4:30 p.m. In addition, the administrator explained, at the time of record review, the corporate office had directed the facility to engage another sprinkler contractor "around the first of the (2010) year. The new contractor never showed up." The administrator said he recontracted with the former sprinkler inspection contractor who performed a July quarterly inspection and then the annual check in November for which there was an incomplete record of test results. 3.1-19(b)	K 062		
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review, observation and interview; the facility failed to ensure 1 of 1 commercial cooking extinguishing systems was maintained. NFPA 96, 7-2.2 requires automatic fire extinguishing systems shall comply with standard UL 300, Fire Testing of Fire Extinguishing Systems for Protection of Restaurant Cooking Areas. This deficient practice could affect kitchen staff and an undetermined number of visitors and residents in the adjacent main dining room. Findings include:	K 069	K 069 1. The automatic fire extinguishing system was updated to comply with standard UL 300, Fire Testing of Fire Extinguishing Systems for Protection for Restaurant Cooking Areas. 2. There are not any other commercial cooking extinguishing systems in the facility to review and update. All systems in the facility are currently updated. 3. The maintenance director was in-serviced to ensure commercial cooking extinguishing systems remain up to date with the most current regulations. 4. The administrator will review any new regulations regarding commercial cooking extinguishing systems with the maintenance director to ensure the facility remains in compliance. 5. Completion date 3/5/11	

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K 069	Continued From page 9 Based on review of the last commercial kitchen range hood Fire Equipment Service Report dated 08/17/10 with the maintenance director and administrator on 02/03/11 at 2:05 p.m., the record noted "not UL 300." The administrator said at the time of record review, he did not know the extinguishing system should have been upgraded. 3.1-19(b)	K 069		
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure a resident room in 1 of 13 smoke compartments used to store oxygen was separated by construction with a one hour fire resistance rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a) requires at least one hour fire resistant enclosures shall be provided for the storage of oxidizing agents such	K 076	K 076 1. The liquid oxygen container in room 309 was removed and placed in the oxygen storage area. The oxygen e-cylinders located in the respiratory storage supply room/office were removed and placed in the appropriate oxygen storage area. 2. All oxygen storage containers were inspected to ensure they are stored properly. 3. The respiratory therapist and maintenance director were re-	

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K 076	Continued From page 10 as oxygen. This deficient practice affects staff, visitors and 31 residents on 2 West. Findings include: Based on observation with the maintenance director and administrator on 02/03/11 at 3:45 p.m., one liquid oxygen container (181 L capacity) was observed in semi private resident room 309. The tank was not in use. LPN # 1 was asked about the oxygen container at the time of observation. She said the resident who had used the oxygen had been transferred to the hospital "a couple of weeks ago." The door separating the room from the corridor was rated for 20 minutes. The maintenance director agreed at the time of observation and interview, the oxygen tank should not have been stored in the resident room. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure oxygen stored in 1 of 2 sprinklered storage areas for oxidizing gases, such as oxygen, were properly separated from combustibles. NFPA 99, Health Standards for Health Care Facilities, and NFPA 99, 8-3.1.11.2(c) requires the minimal separations from oxygen and combustibles in a sprinklered building be 5 feet or an enclosed cabinet of noncombustible construction having a minimum fire protection rating of one half hour for cylinder storage. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. This deficient practice affects residents staff and visitors on the main hall with a census of 50 residents. Findings include:	K 076	educated to ensure the proper storage of oxygen in the facility. 4. The administrator or designee will check the storage of oxygen during the daily rounds to ensure the correct storage of oxygen. 5. Completion date 3/5/11	

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K 076	Continued From page 11 Based on observation with the maintenance director and administrator on 02/03/11 at 4:10 p.m., the ten by ten foot respiratory storage supply room/office was used for plastic, paper and cardboard wrapped respiratory supplies on shelves located immediately adjacent to four oxygen e-cylinders stored in the room. The maintenance director said at the time of observation, he was unaware of the separation requirement.	K 076		
K 103 SS=E	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the construction of a wall separating two rooms on the first floor in this building of Type II construction was built with noncombustible or limited combustible materials to protect 32 of 32 residents on the first floor. This deficient practice affects staff, visitors and 32 residents on the first floor. Findings include: Based on observation with the maintenance director and administrator on 02/03/11 at 2:45 p.m., the wall above the suspended ceiling and separating resident rooms 117 and 116 was finished on the north side of the wood studs with	K 103	K 103 1. The south face of the wall between room 116 and 117 was finished with drywall. 2. All walls separating two rooms were inspected to ensure they were built with noncombustible or limited combustible materials. 3. The maintenance director was in-serviced to ensure all walls separating two rooms were finished with drywall. 4. The administrator toured with the maintenance director to inspect all walls in the facility to ensure they were finished with drywall. 5. Completion date 3/5/11	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 103	Continued From page 12 drywall. The south face of the wall was unfinished, leaving exposed wood studs. There was nothing to indicate the studs were treated to be fire resistant and the maintenance director said he didn't know the wall was unfinished and could not provide evidence the studs were fire resistant. 3.1-(19)b	K 103		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: 1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas	K 144	K 144 1. A remote shut off switch was added to the facility generator. The annunciator remote alarm was further reviewed after the Life Safety inspection was completed. Please note, the current annunciator panel does indicate the generator is being used and does alert battery and temperature problems. The current	

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	155448	A. BUILDING 01 B. WING _____	02/03/2011

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K 144	Continued From page 13 Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on review of the emergency generator Preventive Maintenance Records on 02/03/11 at 1:50 p.m. with the maintenance director and administrator, the emergency generator was installed in 2006. The maintenance director said at the time of record review, the generator did not have a remote emergency shut off. 3.1-19(b) 2. Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure.	K 144	annunciator remote alarm will continue to be used. A letter of reliability was obtained with a signature from a technical personnel. 2. There are not any other generators in the facility to review. 3. The maintenance director was in-serviced regarding the items needed to be monitored by the generator annunciator panel, the items needed on the generator gas reliability letter, and the need for an automatic cut off switch for the generator to ensure all items are installed, inspected, and up to date at all times. 4. The administrator will inspect the emergency shut off switch, annunciator panel, and reliability letter with the maintenance director to ensure all items are working and correct. 5. Completion date 3/5/11	

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K 144	Continued From page 14 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all the residents as well as visitors and staff. Findings include: Based on observation with the maintenance director and administrator on 02/03/11 at 4:15 p.m., a remote alarm annunciator for the emergency generator was provided near the first floor nurses station which was continuously occupied. At the time, the generator was running. Close inspection of the annunciator revealed the annunciator did not indicate the generator was running and connected to power nor did it appear to have the capacity to alert battery and temperature problems. The maintenance director said at the time of observation, he thought the annunciator had the capability but a review of the digital readings noted only the history of oil changes. 3.1-19(b) 3. Based on observation, record review and interview; the facility failed to provide evidence the off site fuel source for 1 of 1 emergency	K 144		

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K 144	Continued From page 15 generators was from a reliable source. NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), onsite storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. CMS allows a facility with a natural gas generator to meet the requirements for an on site backup power source that does not require a letter from its natural gas vendor. The letter of reliability from the vendor regarding fuel supply must contain all of the following: 1. A statement of reasonable reliability of the natural gas delivery; 2. A brief description supporting the statement of reliability; 3. A statement that there is a low probability of interruption of the natural gas; 4. A brief description supporting the statement for the low probability of interruption; 5. The signature of technical personnel from the	K 144		

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K 144	Continued From page 16 natural gas vendor. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the administrator and maintenance director on 01/06/10 at 2:15 p.m., the only fuel source for the emergency generator was natural gas. The administrator provided a copy of a letter from the natural gas provider on 02/03/11 at 1:45 p.m. He said the letter had been previously approved, however, the letter dated 1/12/10 was incomplete as it did not meet all the elements required as evidence of their reliability to provide fuel for the generator. The letter was signed by the manager of gas transportation who the administrator said at the time of review should have technical knowledge.	K 144		
K 147 SS=E	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring. NFPA 70 (National Electrical Code), 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 34 residents on the second floor.	K 147	K 147 1. The power strip extension cord was removed. The electrical conjunction box was covered. 2. All suspended ceiling areas were inspected to ensure there were not any power strip extension cords located above the ceiling. All conjunction boxes were inspected to ensure a cover was placed over all boxes.	

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K 147	Continued From page 17 Findings include: Based on observation with the maintenance director on 02/03/11 at 3:20 p.m., a power strip extension cord was use to provide power to equipment above the suspended ceiling at the south stairway smoke barrier. The maintenance director said at the time of observation, he didn't know the power strip was there. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes observed was maintained in a safe operating condition. NFPA 70, National Electrical Code, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect visitors, staff and 32 residents on the first floor. Findings include: Based on observation with the maintenance director on 02/03/11 at 2:45 p.m., an electrical junction box was uncovered in the space above the suspended ceiling over the smoke barrier near room 117. The maintenance director agreed at the time of observation, the junction box should have been covered. 3.1-19(b)	K 147	3. The maintenance director was in-serviced to ensure power strip extension cords are not used against the facility policy and to ensure conjunction boxes remain covered at all times. 4. The maintenance director will tour with the administrator to ensure all conjunction boxes are covered and there are not any power strip extension cords used against facility policy. 5. Completion date 3/5/11	